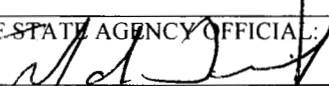



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 0 4 - 0 0 4	2. STATE GEORGIA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE September 1, 2004	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 435.731;831; Sections 1917(d) and 1902(a)(17) of The Act.		7. FEDERAL BUDGET IMPACT:	
		a. FFY 2004 \$ * * Cost b. FFY 2005 \$ * * Neutra;	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.6-A, pp 14, 26 Attachment 3.1-B. p 2		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 2.6-A, pp 14, 26 Attachment 3.1-B. p 2	
10. SUBJECT OF AMENDMENT: ELIMINATION OF ADULT MEDICAL NEEDY NH AND HOSPICE (INSTITUTIONAL) PROGRAMS			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED:			
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME - MARK TRAIL		Department of Community Health Medical Assistance Plans 2 Peachtree Street, N.W. Atlanta, Georgia 30303-3159	
14. TITLE: CHIEF, MEDICAL ASSISTANCE PLANS			
15. DATE SUBMITTED: June 28, 2004			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: JUL 06 2004		18. DATE APPROVED: OCT 04 2004	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP 01 2004		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: RENARD L. MURRAY, D.M.		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS: Approved with the following changes to Items 8 and 9 that were Authorized by the State on letter dated 9/2/04: Delete Attachment 2.6-A, pages 14, 16 Add Attachment 3.1-B, page 6			

State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

-
1. Inpatient hospital services other than those provided in an institution for mental diseases.
- X Provided: No limitations X With limitations*
2. a. Outpatient hospital services.
- X Provided: No limitations X With limitations*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise covered under the plan.
- X Provided: No limitations X With limitations*
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medical Manual (HCFA-Pub. 45-4).
- X Provided: No limitations X With limitations*
3. Other laboratory and x-ray services.
- X Provided: No limitations X With limitations*
4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- Provided: No limitations With limitations*
- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
- X Provided:
- c. Family planning services and supplies for individuals of childbearing age.
- X Provided: No limitations X With limitations*
- * Description provided on attachment 3.1-A, limitations supplement.

Supersedes
TN No: 9127
Division: HCPA-PM-86-20 (BREC)
SEPTEMBER 1986

ATTACHMENT 3.1-B
Page 6
QMB No. 0938-0193

State/Territory: Georgia

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY ' NEEDY GROUP (S): ALL

-
- | | | | | |
|-----|---|--|--|---|
| c. | Intermediate care facility services. | <input type="checkbox"/> Provided | <input type="checkbox"/> No limitation | <input type="checkbox"/> With limitation |
| 15. | Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902 (a) (31) (A) of the Act, to be in need of such care. | <input type="checkbox"/> Provided | <input type="checkbox"/> No limitation | <input type="checkbox"/> With limitation |
| 16. | Inpatient psychiatric facility services for individuals under 22 years of age. | <input type="checkbox"/> Provided | <input type="checkbox"/> No limitation | <input type="checkbox"/> With limitation |
| 17. | Nurse-midwife services. | <input checked="" type="checkbox"/> Provided | <input type="checkbox"/> No limitation | <input checked="" type="checkbox"/> With limitation |
| 18. | Hospice care (in accordance with section 1905 (o) of the Act). | <input type="checkbox"/> Provided | <input type="checkbox"/> No limitation | <input type="checkbox"/> With limitation |

Description provided on attachment.

TN No: 04-004
Supersedes
TN No: 01-06

Approval Date OCT 04 2004

Effective Date SEP 01 2004